

Commentary

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What Aspects of Good Practice in Early Interventions in Psychosis can be Codified in Guidelines? A Reflection on Corsico et al. (2017)

Abstract: In this brief commentary on the paper by Corsico et al. (2017) on how to codify guidelines for EIP, we discuss the role that moral attributes, when expressed at a high level of generality, may usefully play in improving practice. We suggest that behavioural recommendations combined with examples are necessary to provide sufficient orientation to practitioners.

1. Introduction

In their paper ‘What constitutes good practice in early interventions in psychosis? Analysis of clinical guidelines’, Paolo Corsico and his colleagues Michelle Griffin-Doyle and Ilina Singh discuss the specific moral challenges which clinicians and service providers face in early interventions in psychosis (EIP) for adolescents. The rationale behind early interventions is that the development of psychotic illness can be stopped if treatment starts early (as the authors put it, “EIP service users will, ideally, not become patients”, page 6 of manuscript). However, as Corsico and colleagues note, intervening on young people also bears significant risks, as they may be or feel stigmatized, their self-esteem and developing self-image may be damaged, and pharmacological treatment may have severe negative side effects on them. A further concern is that in the at-risk mental state (ARMS) population, early intervention is offered to some people who would not have developed psychosis anyway. So, especially in early intervention, the potential benefits need to be weighed against the risks.

In their very interesting and timely paper, Corsico et al. review and analyse existing guidelines for EIP and then offer some recommendations for improving such guidelines. In their analysis, they identify two kinds of moral requirements that need to be met by EIP, which they label ‘ethical requirements of service delivery’ and ‘moral attributes of clinicians’. They say that “... it will be important to ensure that EIP professionals are enabled to enact both the ethical requirements of service delivery and the moral attributes of clinicians that are at the core of EIP service and care.” (page 7 of manuscript)

As the authors suggest, the identified moral requirements are central to the delivery of good mental health services. But how could they best inform and shape the EIP guidelines? One of the key recommendations made by Corsico et al. is that the required moral attributes of clinicians should be made explicit. We believe that an important consideration in revising any form of guidelines is whether the suggested revisions would motivate the desired change or improvement in the existing practice. In this short commentary, we

consider how moral attributes of individual practitioners can be best specified in order to provide guidance.

Although it is of paramount importance that clinicians possess and exhibit certain moral virtues and that they receive support in developing them as part of their training and ongoing career development, the problem with referring to moral attributes in the guidelines is that the attributes are notoriously underspecified and need further elaboration in order to be converted into action. A further, related concern is that people have the tendency to believe that they are more skilled and talented than is the case, and this applies especially to moral attributes. For instance, the great majority of people would say that they are more kind and generous than average. So clinicians may believe that they already possess the moral attributes listed in the guidelines and, as a consequence, believe that there is nothing they need to do to improve their practice. We elaborate on both of these concerns below and make suggestions as to how guidelines can be designed to avoid the concerns we raise.

2. Moral Attributes and Action Guidance

The moral attributes required of clinicians according to the authors' analysis are *competency, empathy, sensitivity and trustworthiness*. First, it should be noted that these attributes are not normally considered to be *moral* attributes, but they definitely are positive features of agents (some are defined as skills and some as character traits) that can support moral agency. More importantly, competence, empathy, sensitivity and trustworthiness are high-level, abstract attributes and they could show themselves in various forms of behaviour within the clinical encounter. Helpfully, the authors list some behavioural recommendations from the guidelines they have analysed that would match each moral attribute. For example, under the heading 'sensitivity' they list the importance of being respectful of people's sexual orientation, socioeconomic situation, and cultural, ethnic and religious background, and to tailor communication according to people's age and background. These behavioural recommendations help flesh out what the moral attributes mean but are not sufficient to specify how services should be delivered and should be combined with an explicit reference to the goals of practice that they would contribute to fulfil and with a set of concrete examples. It is of course unrealistic to expect rules for every single eventuality. The fact that judgment is needed in order to react flexibly to the demands of a situation is the reason why philosophers like Alasdair MacIntyre (2009) propose a virtue ethical account.

So, behavioural recommendations to be included in the guidelines will have to be described in ways to allow some flexibility, because it is impossible to foresee all circumstances. Our suggestion is that the reference to desirable moral attributes should be supplemented by behavioural recommendations and examples as well as by the inclusion of specific goals

(e.g., avoid prescribing medication to users where possible; offer treatment options so that users can contribute to the decision processes involved in their care; etc.). We believe that a combination of behavioural recommendations linked to higher-level goals and specific examples would be more useful in giving guidance than just a list of moral attributes, without denying a role to the individual clinician's judgement or underestimating the importance of reacting flexibly to the users' needs.

3. Positive Illusions and Action Guidance

In the EIP guidelines offering concrete examples and behavioural recommendations as linked to the general aims of service provision will be helpful to combat another problem which can arise if clinicians are simply handed a list of moral attributes to conform to. If the moral guidance was confined to a list of moral attributes, many clinicians would be likely to believe that they already have the required attributes even when this is not the case, due to a common instance of the *better-than-average* effect. The effect, also known as the superiority illusion (Brown, 2012; Sedikides, Meek, Alicke, & Taylor, 2014), is a self-enhancing bias. It consists in people evaluating themselves as better than average on desirable characteristics. This effect seems to be particularly pronounced in the moral domain (Tappin & McKay) and can be shown even in people who have little reason to think of themselves as morally superior to the average population, such as convicted offenders (Sedikides et al., 2014).

Further, biased judgments are more likely when the desirable attributes are fairly abstract, because people can more easily interpret behavioural evidence about themselves as supporting the claim that they have the desirable attributes to a greater extent than their peers (Dunning, Meyerowitz, & Holzberg, 1989). Thus, the underspecificity of moral attributes may be a threat to the effectiveness of EIP guidelines by allowing unrealistically positive self-assessment when it comes to positive moral attributes. That is why adding behavioural recommendations and supplementing them with examples may help motivate clinicians.

4. Concluding remarks

The concern that including an explicit reference to moral attributes in EIP guidelines will not lead service providers to act more ethically is due to (1) the inherent underspecificity of moral attributes and (2) the risk that people may see themselves as already meeting moral requirements when this is not the case. In this brief commentary, building on the significant contribution made by Corsico and colleagues, we suggested that the concern could be addressed if specific behavioural recommendations were included in the guidelines, and supplemented by examples.

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